		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037002

Facility Name: Lexington of Streamwood

Address: 815 E. Irving Park Road (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (630) 837-5300 **Fax #** (630) 213-9076

IDPA ID Number: 363748803001

Date of Initial License for Current Owners: 07/08/91

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,013	3,085	8,862	41,960	8
9	SNF/PED					9
10	ICF	17,204	961	203	18,368	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,217	4,046	9,065	60,328	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.79%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/08/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 8,103

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	294,754	28,608	17,935	341,297		341,297		341,297			1
2	Food Purchase		233,766		233,766		233,766	(9,836)	223,930			2
3	Housekeeping	255,328	35,942		291,270		291,270	390	291,660			3
4	Laundry	67,440	19,362		86,802		86,802	(2,701)	84,101			4
5	Heat and Other Utilities			202,774	202,774		202,774	3,911	206,685			5
6	Maintenance	67,078		97,820	164,898		164,898	2,488	167,386			6
7	Other (specify):*											7
8	**TOTAL General Services**	684,600	317,678	318,529	1,320,807		1,320,807	(5,748)	1,315,059			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,614,372	279,204	762,193	3,655,769		3,655,769		3,655,769			10
10a	Therapy			748,491	748,491		748,491		748,491			10a
11	Activities	141,886	14,452	3,466	159,804		159,804		159,804			11
12	Social Services	76,922		2,671	79,593		79,593		79,593			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,833,180	293,656	1,540,821	4,667,657		4,667,657		4,667,657			16
	C. General Administration											
17	Administrative	152,878		376,987	529,865		529,865	(376,987)	152,878			17
18	Directors Fees											18
19	Professional Services			60,309	60,309		60,309	11,717	72,026			19
20	Dues, Fees, Subscriptions & Promotions			41,128	41,128		41,128	856	41,984			20
21	Clerical & General Office Expenses	571,319	34,428	27,701	633,448		633,448	24,172	657,620			21
22	Employee Benefits & Payroll Taxes			544,692	544,692		544,692	78,277	622,969			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,943	1,943		1,943	2,968	4,911			24
25	Other Admin. Staff Transportation							9,803	9,803			25
26	Insurance-Prop.Liab.Malpractice			191,923	191,923		191,923	3,839	195,762			26
27	Other (specify):*											27
28	**TOTAL General Administration**	724,197	34,428	1,244,683	2,003,308		2,003,308	(245,355)	1,757,953			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,241,977	645,762	3,104,033	7,991,772		7,991,772	(251,103)	7,740,669			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Streamwood #0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			56,985	56,985		56,985	186,050	243,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,491	20,491		20,491	314,202	334,693			32
33	Real Estate Taxes							416,864	416,864			33
34	Rent-Facility & Grounds			1,605,810	1,605,810		1,605,810	(1,605,810)				34
35	Rent-Equipment & Vehicles			8,332	8,332		8,332	4,256	12,588			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,691,618	1,691,618		1,691,618	(684,438)	1,007,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		215,547		215,547		215,547		215,547			39
40	Barber and Beauty Shops			15,086	15,086		15,086		15,086			40
41	Coffee and Gift Shops			4,714	4,714		4,714		4,714			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Costs			112,652	112,652		112,652	(112,652)				43
44	**TOTAL Special Cost Centers**		215,547	255,092	470,639		470,639	(112,652)	357,987			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,241,977	861,309	5,050,743	10,154,029		10,154,029	(1,048,193)	9,105,836			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(171)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,701)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(209)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(831)	43		13
14	Non-Care Related Interest	(9,689)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,110)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,830)	43		24
25	Fund Raising, Advertising and Promotional	(15,984)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	107,905			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,627)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,043,566)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,043,566)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,048,193)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/03 - 12/31/03 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections and out of period legal fees	(3,433)	19
Offset miscellaneous income	(168)	21
Nonallowable personal item replacement	(498)	43
Unrealized gain on fair value of an interest rate swap	124,403	43
Nonallowable radiology expense	(8,090)	43
Nonallowable laboratory expense	(4,309)	43
Total	107,905	

See Accountants' Compilation Report

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(171)	0	0	0	0	0	0	0	0	0	0	(171)	2
3	Housekeeping	0	0	390	0	0	0	0	0	0	0	0	390	3
4	Laundry	(2,701)	0	0	0	0	0	0	0	0	0	0	(2,701)	4
5	Heat and Other Utilities	0	0	3,911	0	0	0	0	0	0	0	0	3,911	5
6	Maintenance	0	0	2,488	0	0	0	0	0	0	0	0	2,488	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,872)	0	6,789	0	0	0	0	0	0	0	0	3,917	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(376,987)	0	0	0	0	0	0	0	(376,987)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,680	11,600	0	0	0	0	0	0	0	0	24,280	19
20	Fees, Subscriptions & Promotions	0	0	856	0	0	0	0	0	0	0	0	856	20
21	Clerical & General Office Expenses	0	100	24,240	0	0	0	0	0	0	0	0	24,340	21
22	Employee Benefits & Payroll Taxes	0	0	68,612	0	0	0	0	0	0	0	0	68,612	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,968	0	0	0	0	0	0	0	0	2,968	24
25	Other Admin. Staff Transportation	0	0	0	9,803	0	0	0	0	0	0	0	9,803	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,839	0	0	0	0	0	0	0	3,839	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	12,780	108,276	(363,345)	0	0	0	0	0	0	0	(242,289)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,872)	12,780	115,065	(363,345)	0	0	0	0	0	0	0	(238,372)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	154,059	0	31,991	0	0	0	0	0	0	0	186,050	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,898)	323,743	0	357	0	0	0	0	0	0	0	314,202	32
33	Real Estate Taxes	0	405,810	0	1,924	0	0	0	0	0	0	0	407,734	33
34	Rent-Facility & Grounds	0	(1,605,810)	0	0	0	0	0	0	0	0	0	(1,605,810)	34
35	Rent-Equipment & Vehicles	0	0	0	4,256	0	0	0	0	0	0	0	4,256	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,898)	(722,198)	0	38,528	0	0	0	0	0	0	0	(693,568)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(99,762)	(124,396)	0	0	0	0	0	0	0	0	0	(224,158)	43
44	**TOTAL Special Cost Centers**	(99,762)	(124,396)	0	0	0	0	0	0	0	0	0	(224,158)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,532)	(833,814)	115,065	(324,817)	0	0	0	0	0	0	0	(1,156,098)	45

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Streamwood Limited Partnership	Streamwood	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Streamwood Limited Partnership	**	$ 12,680	$ 12,680	1
2	V	21	Bank charges		Sambell of Streamwood Limited Partnership	**	100	100	2
3	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	154,059	154,059	3
4	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	318,775	318,775	4
5	V	32	Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	4,968	4,968	5
6	V	33	Property taxes		Sambell of Streamwood Limited Partnership	**	405,810	405,810	6
7	V	34	Rental expense	1,605,810	Sambell of Streamwood Limited Partnership	**		(1,605,810)	7
8	V	43	State replacement tax		Sambell of Streamwood Limited Partnership	**	7	7	8
9	V	43	Unrealized gain on fmv of interest rate swap		Sambell of Streamwood Limited Partnership	**	(124,403)	(124,403)	9
10	V								10
11	V								11
12	V		** The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood Limited Partnership						12
13	V								13
14	Total			$ 1,605,810			$ 771,996	$ * (833,814)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 390	$ 390	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,841	3,841	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	70	70	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	2,416	2,416	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	72	72	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	8,740	8,740	20
21	V	19	Professional fees		Royal Management Corp.	**	2,860	2,860	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	194	194	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	662	662	23
24	V	21	Bank charges		Royal Management Corp.	**	3,360	3,360	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	7,675	7,675	25
26	V	21	Postage		Royal Management Corp.	**	3,452	3,452	26
27	V	21	Telephone		Royal Management Corp.	**	9,753	9,753	27
28	V	22	FICA		Royal Management Corp.	**	30,989	30,989	28
29	V	22	FUTA		Royal Management Corp.	**	557	557	29
30	V	22	SUTA		Royal Management Corp.	**	964	964	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	587	587	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	30,626	30,626	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	4,889	4,889	33
34	V	24	Travel & seminar		Royal Management Corp.	**	2,968	2,968	34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 115,065	$ * 115,065	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 9,803	$ 9,803	15
16	V	26	Insurance general		Royal Management Corp.	**	3,839	3,839	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,400	3,400	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,950	7,950	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	20,641	20,641	19
20	V	32	Interest		Royal Management Corp.	**	357	357	20
21	V	33	Property taxes		Royal Management Corp.	**	1,924	1,924	21
22	V	35	Equipment rental		Royal Management Corp.	**	4,256	4,256	22
23	V	17	Management fees	376,987	Royal Management Corp.	**		(376,987)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 376,987			$ 52,170	$ * (324,817)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule B**
1/1/03 - 12/31/03

VII. Related Parties

Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Related Nursing Homes	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	10%	Salary	$ 35,468	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	3	12%	Salary	22,167	L17, C1	2
3	Cynthia Thiem	Owner/officer	Adminstrative	22.34%	See Schedule C	2	13%	Salary	17,734	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	5,320	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	13,522	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,211		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule C**
1/1/03 - 12/31/03

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	177,833	284,532	142,266	42,680	108,478	755,789

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	81,760	$ 390	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		81,760	3,841	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		81,760	70	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		81,760	2,416	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		81,760	72	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		81,760	8,740	6
7	19	Professional fees	Bed Days	737,665	10	25,806		81,760	2,860	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		81,760	194	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		81,760	662	9
10	21	Bank charges	Bed Days	737,665	10	30,319		81,760	3,360	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		81,760	7,675	11
12	21	Postage	Bed Days	737,665	10	31,145		81,760	3,452	12
13	21	Telephone	Bed Days	737,665	10	87,995		81,760	9,753	13
14	22	FICA	Bed Days	737,665	10	279,595		81,760	30,989	14
15	22	FUTA	Bed Days	737,665	10	5,021		81,760	557	15
16	22	SUTA	Bed Days	737,665	10	8,695		81,760	964	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		81,760	587	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		81,760	30,626	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		81,760	4,889	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		81,760	2,968	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 115,065	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	81,760	$ 9,803	1
2	26	Insurance general	Bed Days	737,665	10	34,634		81,760	3,839	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		81,760	3,400	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		81,760	7,950	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		81,760	20,641	5
6	32	Interest	Bed Days	737,665	10	3,219		81,760	357	6
7	33	Property taxes	Bed Days	737,665	10	17,360		81,760	1,924	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		81,760	4,256	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 52,170	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	X		Mortgage	Varies	02/01/96	5,985,000	4,859,166	02/01/2026	Variable	318,775	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working capital	None	Various	1,154,048	834,505	Demand	0.0200	9,689	6
7	LaSalle Bank N.A.		X	Working capital	None	04/06/02	900,000		04/04/2004	Prime	10,802	7
8												8
9	TOTAL Facility Related						$ 8,039,048	$ 5,693,671			$ 339,266	9
	B. Non-Facility Related*											
10							Amortization of mortgage costs				4,968	10
11							Interest income offset				(209)	11
12							Nonallowable shareholder interest				(9,689)	12
13							Allocated from management company				357	13
14	TOTAL Non-Facility Related						$	$			$ (4,573)	14
15	TOTALS (line 9+line14)						$ 8,039,048	$ 5,693,671			$ 334,693	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 462,000	1
	Allocated from management company	1,924	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 444,124	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,952)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 424,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 9,130	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 514 For 96 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (514)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 416,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	445,743	8
1999	448,359	9
2000	454,959	10
2001	438,043	11
2002	444,124	12

2003 assessment:	1,957,758
Equalization factor:	2.469
Tax Rate:	0.088
Est 03 taxes payable 04:	424,140
Use:	424,200

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Streamwooc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 444,124.07	$ 444,124.07
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 212,239.00	$ 1,924.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 656,363.07	$ 446,048.07

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1991	$ 211,400	1
2	Mgmt. Co.		2002	17,683	2
3	TOTALS	30,000		$ 229,083	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1991	1,991	$ 5,248,322	$	35	$ 149,952	$ 149,952	$ 1,874,401	4
5	10		1993	1,993	105,236		35	3,007	3,007	28,564	5
6	14		1995	1,995	82,650	2,361	35	2,361		20,071	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	2,205	9
10	Land Improvements			1995	7,000	467	15	467		3,968	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		2,640	11
12	Piping			1996	3,139	90	35	90		674	12
13	Basement remodeling			1997	20,204	2,020	10	2,020		12,794	13
14	Floor Repairs			1997	555	56	10	56		340	14
15	Corner Guards			1997	998	100	10	100		608	15
16	Corner Guards			1998	3,563	356	10	356		1,958	16
17	Wiring			1998	2,050	205	10	205		1,128	17
18	Tile			1998	11,696	1,170	10	1,170		5,850	18
19	Patio			1999	12,011	801	15	801		3,271	19
20	Parking lot			2000	1,773	177	10	177		620	20
21	110-ton A/C Unit			2000	6,922	692	10	692		2,422	21
22	Rods for bedside curtains			2000	5,872	587	10	587		1,469	22
23	Automatic Doors			2000	1,300	130	10	130		455	23
24	Rehab project: carpeting, wallcovering, handrails, painting			2000	85,196	8,519	10	8,519		29,817	24
25	Compressor / tube bundles-cooling system			2001	12,922	1,292	10	1,292		3,230	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		26,527	26
27	Parking lot			2002	29,288	2,929	10	2,929		4,393	27
28	Office area rehab			2002	26,991	1,350	20	1,350		2,025	28
29	Elevator interior upgrade			2002	1,120	112	10	112		177	29
30	Gazebo			2002	3,393	339	10	339		509	30
31	Elevator electronic curtains			2002	4,500	450	10	450		862	31
32	Door frame protector			2003	5,276	484	10	484		484	32
33	Rehab project-kitchen: carpeting, painting, wallcovering, wiring			2003	9,392	391	10	391		391	33
34	Roof			2003	29,950	125	20	125		125	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 11,208	$	35	$ 332	$ 332	$ 2,722	37
38	Leasehold improvements - management company	1996	9,121		35	270	270	1,955	38
39	Leasehold improvements - management company	1989	314		31	9	9	158	39
40	HVAC - management company	1998	236		35	7	7	40	40
41	Offices - management company	1999	596		35	18	18	77	41
42	Land improvements - management company	2002	27,870		15	826	826	3,561	42
43	Building - management company	2002	216,828		40	6,433	6,433	10,390	43
44	HVAC, electrical, security system - management company	2003	2,149		30	55	55	55	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,221,510	$ 36,166		$ 197,285	$ 161,119	$ 2,050,936	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 189,333	$ 20,296	$ 21,186	$ 890	5-10 years	$ 121,116	71
72	Current Year Purchases	6,843	523	523		5-10 years	523	72
73	Fully Depreciated Assets	414,865					414,865	73
74	Allocated from Mgmt. Co.	198,468		20,641	20,641		65,776	74
75	TOTALS	$ 809,509	$ 20,819	$ 42,350	$ 21,531		$ 602,280	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			33,164		3,400	3,400		26,478	79
80	TOTALS			$ 33,164	$	$ 3,400	$ 3,400		$ 26,478	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,293,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,985	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,035	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 186,050	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,679,694	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,588 Description: Copier $8,062 , Fax $270; Allocated from management company $4,256
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	23,429	$ 342,428	$	23,429	$ 342,428	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,304	57,137		2,304	57,137	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		31,456	337,493		31,456	337,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				215,547		215,547	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound therapy					11,433			11,433	13
14	TOTAL			$	57,189	$ 748,491	$ 215,547	57,189	$ 964,038	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 62,177	$ 125,821	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 460,657)	1,617,495	1,617,495	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,038	4,038	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	91,998	90,738	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,775,708	$ 1,838,092	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	57,196	57,196	12
13	Land		229,083	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	592,294	867,952	15
16	Equipment, at Historical Cost	222,267	842,673	16
17	Accumulated Depreciation (book methods)	(271,569)	(2,679,694)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		87,999	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 600,188	$ 4,758,767	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,375,896	$ 6,596,859	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 581,453	$ 581,453	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	834,505	834,505	29
30	Accrued Salaries Payable	260,779	260,779	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,246	3,246	31
32	Accrued Real Estate Taxes(Sch.IX-B)		424,200	32
33	Accrued Interest Payable		40,135	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	1,377,067	121,881	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,057,050	$ 2,266,199	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,859,166	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap liability		402,063	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,261,229	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,057,050	$ 7,527,428	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (681,154)	$ (930,569)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,375,896	$ 6,596,859	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/03 - 12/31/03 **Schedule E**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	1,255,186	-
Accrued management fees	30,349	30,349
Accrued 401 (k) contribution	5,726	5,726
Other accrued expenses	85,806	85,806
Total line 36	1,377,067	121,881

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	168
Investment Income in Lexington Financial Services, LLC	479
Total line 28	647

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 356,204	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 356,204	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,037,358)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,037,358)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (681,154)	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,158,234	1
2	Discounts and Allowances for all Levels	(958,818)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,199,416	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,304,992	6
7	Oxygen	2,051	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,307,043	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,355	12
13	Barber and Beauty Care	18,644	13
14	Non-Patient Meals	171	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	383,418	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,893	19
20	Radiology and X-Ray	11,868	20
21	Other Medical Services	142,306	21
22	Laundry	2,701	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 609,356	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	209	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 209	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	647	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 647	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,116,671	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,320,807	31
32	Health Care	4,667,657	32
33	General Administration	2,003,308	33
	B. Capital Expense		
34	Ownership	1,691,618	34
	C. Ancillary Expense		
35	Special Cost Centers	347,999	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,154,029	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,037,358)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,037,358)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,635	1,999	$ 69,198	$ 34.62	1
2	Assistant Director of Nursing	3,140	3,899	107,636	27.61	2
3	Registered Nurses	33,296	36,522	1,043,772	28.58	3
4	Licensed Practical Nurses	12,084	13,207	303,826	23.00	4
5	Nurse Aides & Orderlies	82,001	86,876	1,018,908	11.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,805	5,412	71,032	13.12	8
9	Activity Director	482	829	14,878	17.95	9
10	Activity Assistants	13,252	14,074	127,008	9.02	10
11	Social Service Workers	3,896	4,349	76,922	17.69	11
12	Dietician	1,477	1,698	29,257	17.23	12
13	Food Service Supervisor	1,979	2,174	29,505	13.57	13
14	Head Cook	1,836	2,196	29,498	13.43	14
15	Cook Helpers/Assistants	10,791	11,741	96,718	8.24	15
16	Dishwashers	16,684	17,587	109,776	6.24	16
17	Maintenance Workers	3,946	4,522	67,078	14.83	17
18	Housekeepers	35,074	38,290	255,328	6.67	18
19	Laundry	10,000	10,630	67,440	6.34	19
20	Administrator	936	1,338	58,667	43.85	20
21	Assistant Administrator					21
22	Other Administrative	714	717	94,211	131.40	22
23	Office Manager					23
24	Clerical	25,325	29,675	571,319	19.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	263,353	287,735	$ 4,241,977 *	$ 14.74	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	255	$ 17,935	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	22	1,100	L10, C3	37
38	Nurse Consultant	Per assmt	1,406	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,466	L11, C3	44
45	Social Service Consultant	58	2,671	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	335	$ 51,778		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	18,518	$ 453,695	L10, C3	50
51	Licensed Practical Nurses	7,957	175,062	L10, C3	51
52	Nurse Aides	487	8,030	L10, C3	52
53	TOTAL (lines 50 - 52)	26,962	$ 636,787		53

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Samatas	Admin/Plant Ops	22.33%	$ 22,167
James Samatas	Administrative	22.33%	35,468
Cynthia Thiem	Administrative	22.34%	17,734
George Samatas	Administrative	0.00%	5,320
Jason Samatas	Administrative	0.00%	13,522
See attached Schedule F1			58,667
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 152,878

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 376,987
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 376,987

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 20,746
Amalgamated	Bond Admin Fee	475
American Express Tax & Bus. Svcs.	Accounting	4,916
Carilyn Jeschke	Staffing Consultant	3,886
Freedman, Anselmo & Lindberg	Collections	429
Gilson, Labus & Silverman	Accounting	78
ING	401(k) Consulting	375
Moody's	Refund of Annual Bond Fee	(1,175)
Personnel Planners	U/C Consulting	1,965
James Samatas, Atty at Law	Legal	97
Sachnoff & Weaver	Legal	16,612
See attached Schedule F2		11,905
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 60,309

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,367
Unemployment Compensation Insurance	24,388
FICA Taxes	308,869
Employee Health Insurance	202,546
Employee Meals	9,665
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	8,520
Other Employee Benefits	7,614
TOTAL (agree to Schedule V, line 22, col.8)	$ 622,969

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	39,072
Health Care Worker Background Check	
(Indicate # of checks performed 83)	1,000
Miscellaneous Dues & Subscriptions	80
Miscellaneous Licenses & Permits	1,170
Allocated from management company	662
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,984

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,943
Allocated from management company	2,968
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,911

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/03 - 12/31/03

Schedule F1

XIX. Support Schedules
A. Administrative Salaries

Name	Function	Ownership	Amount
Chris Anderson	Administrator	0.00%	19,308
Randi Kenard	Administrator	0.00%	20,534
Esther Davis	Administrator	0.00%	12,606
Lynn Ryan	Administrator	0.00%	6,219
Total			58,667

See Accountants' Compilation Report

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule F2**
1/1/03 - 12/31/03

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
KMZRosenman	Legal	4,704
Scott & Krause	Legal	542
Advanced Answers on Demand	Computer consulting	2,652
Action Computer Services	Computer consulting	346
Gigatrend	Computer consulting	195
Telenet Communications	Computer consulting	359
Krakau Business	Computer consulting	493
AdminaStar Federal fee	Computer consulting	378
E Health Solutions	Computer consulting	1,080
Information Controls, Inc.	Computer consulting	1,156
		11,905
Total, Agrees to Schedule V, Line 19, Column 3		60,309
Allocated from management co.		
American Express Tax & Business Services	Accounting	623
Gilson, Labus and Silverman	Accounting	57
James Samatas	Legal	77
Katten, Muchin, Zavis and Rosenman	Legal	72
Sachnoff and Weaver	Legal	566
ING / Pension Administrators	401 (k) Administration	764
Various	Consulting	701
Various	Computer Consulting	8,740
Allocated from building partnership		
James Samatas	Filing and recording fees	50
McCracken, Walsh, DeLavan & Hetler	Real estate tax appeal fees	9,130
JSO Valuation Group, Ltd.	Appraisal fees	3,500
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(429)
Sachnoff and Weaver	Legal-out of period fees	(2,719)
Katten, Muchin, Zavis and Rosenman	Legal-out of period fees	(285)
Reclassifications		
McCracken, Walsh, DeLavan & Hetler	Legal	(9,130)
Total, Agrees to Schedule V, Line 19, Column 8		72,026

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7							N/A						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,263** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,665** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **171**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Streamwood** **12:22 PM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS		COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,048,193	equal to	-1,048,193	0	O.K.		Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	334,693	equal to	334,693	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	416,864	equal to	416,864	0	FAILED		Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	243,035	equal to	243,035	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,588	equal to	12,588	0	O.K.		Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	737,058	equal to	748,491	-11,433	FAILED	ok wound therapy on sched d	Pg16 Z12+Z14..:	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	215,547	equal to	#VALUE!	#VALUE!	#VALUE!		Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,320,807	equal to	1,320,807	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,667,657	equal to	4,667,657	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,003,308	equal to	2,003,308	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,691,618	equal to	1,691,618	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	347,999	equal to	347,999	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.		Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,543,340	equal to	2,614,372	-71,032	FAILED	ok rehab therapy aides	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.		Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.		Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	141,886	equal to	141,886	0	O.K.		Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	76,922	equal to	76,922	0	O.K.		Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	294,754	equal to	294,754	0	O.K.		Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	67,078	equal to	67,078	0	O.K.		Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	255,328	equal to	255,328	0	O.K.		Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	67,440	equal to	67,440	0	O.K.		Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	152,878	equal to	152,878	0	O.K.		Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	571,319	equal to	571,319	0	O.K.		Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.		Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,241,977	equal to	4,241,977	0	O.K.		Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	17,935	< or = to	17,935	0	O.K.		Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.		Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	640,493	< or = to	762,193	-121,700	O.K.	ok oxygen, rehab, equip	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,466	< or = to	3,466	0	O.K.		Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,671	< or = to	2,671	0	O.K.		Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	152,878	equal to	152,878	0	O.K.		Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	376,987	equal to	376,987	0	O.K.		Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	60,309	equal to	60,309	0	O.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	622,969	equal to	622,969	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	41,984	equal to	41,984	0	O.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,911	equal to	4,911	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,665	< or = to	78,277	-68,612	O.K.	ok royal allocation	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,665	equal to	9,665	0	O.K.	ok employee meals	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.		Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,103	equal to	8,862	-759	FAILED	ok medicare days	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-1,043,566	equal to	-1,043,566	0	O.K.		Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,693,671	equal to	5,693,671	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	424,200	equal to	424,200	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	229,083	equal to	229,083	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,221,510	equal to	6,221,510	0	O.K.		Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	842,673	equal to	842,673	0	O.K.		Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,679,694	equal to	2,679,694	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-681,154	equal to	-681,154	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-1,037,358	equal to	-1,037,358	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.		Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,375,896	equal to	2,375,896	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/4/2005		12:22:59 PM		
HSA Number	?	Name	Lexington of Streamwood				
Cost report period	From:	01/01/03	To:	12/31/03	Base Number		336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	81,760	Occupancy:	60,328	Pct. of occupancy:	73.79%		
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	684,600	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	724,197	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	4,241,977	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	622,969	Col 8, Line 22 ---Audit Adj:					
Total General Services:	1,315,059	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,757,953	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$684,600
Divided by Total Wages (Column 1, Line 44	$4,241,977
General service wages as percent of total wages	16.1387%
Employee Benefits (Column 10, Line 22	$622,969
Allocation of Employee Benefits to General Services Costs	$100,539
Plus Total General Services (Column 10, Line 8	$1,315,059
New Total General Services Cost	$1,415,598

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$724,197
Divided by Total Wages (Column 1, Line 45	$4,241,977
General administration wages as a percent of total wages	17.0722%
Employee Benefits (Column 10, Line 22	$622,969
Allocation of Emplayee Benefits to General Admin. Cost	$106,355
Plus Total General Administration (Column 10, Line 2	$1,757,953
Minus Total Fringe (Column 10, Line 22	$622,969
New Total General Administration Cos	$1,241,339

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,415,598	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,415,598

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$1,241,339	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$1,241,339
3 Total Updated Support Costs (1 + 2		$2,656,937

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cost

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $40.52

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,656,937
Total Patient Days (Cost Report	60,328
Support Costs per Diem	$44.04

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	81,760
Multiplied by	0.93
	76,037
Minus total Patient Days	60,328
	15,709
One-third of difference	5,236
Plus Total Patient Day	60,328
Adjusted Occupancy	65,564
Total Support Costs (Step II, C, 3, above	$2,656,937
Divided by Adjusted Occupany	65564
Support Costs Per Diem	$40.52

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$40.52
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Diem	$40.52
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Diem	$40.52
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Diem	$40.52
Support Rate if support costs less than 35th percentile	#N/A

D. **YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above** **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED
TO THE COST REPORT!!!! 11/4/2005 12:22:59 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington of Streamwood** ID: **0037002**

HSA No.: ? Own or Rent? (O or R): ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	224	Total Patient Days	60,328
Begin	01/01/03	Licensed Bed Days:	81,760	% Occupied	73.79%
End	12/31/03			Capital Days	76,037

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1992
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	6221510
2. Total licensed beds from cost report Page 2, Line 7, column 3	224
3. Line 1 divided by Line 2	$27,775
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:	
1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	76,037
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A
Capital Days The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)	
1. Total Patient Days	60,328
2. Total Licensed Bed Days * .93	76037
3. Capital Days (higher of Line 1 or Line 2)	76,037
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	91	5248322	477597302	12
2	2	93	105236	9786948	12
3	3	95	82650	7851750	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	93	7336	682248	12
7	7	95	7000	665000	12
8	8	96	12316	1182336	12
9	9	96	3139	301344	12
10	10	97	20204	1959788	12
11	11	97	555	53835	12
12	12	97	998	96806	12
13	13	98	3563	349174	12
14	14	98	2050	200900	12
15	15	98	11696	1146208	12
16	16	99	12011	1189089	12
17	17	100	1773	177300	12
18	18	100	6922	692200	12
19	19	100	5872	587200	12
20	20	100	1300	130000	12
21	21	100	85196	8519600	12
22	22	101	12922	1305122	12
23	23	101	212217	21433917	12
24	24	102	29288	2987376	12
25	25	102	26991	2753082	12
26	26	102	1120	114240	12
27	27	102	3393	346086	12
28	28	102	4500	459000	12
29	29	103	5276	543428	12
30	30	103	9392	967376	12
31	31	103	29950	3084850	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	95	11208	1064760	12A
35	35	96	9121	875616	12A
36	36	89	314	27946	12A
37	37	98	236	23128	12A
38	38	99	596	59004	12A
39	39	102	27870	2842740	12A
40	40	102	216828	22116456	12A
41	41	103	2149	221347	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

574394502 6221510 92.3239699

Base Year = 1992

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	294,754	28,608	17,935	341,297	0	341,297	0	341,297
2. Food Purchase	0	233,766	0	233,766	0	233,766	-9,836	223,930
3. Housekeeping	255,328	35,942	0	291,270	0	291,270	390	291,660
4. Laundry	67,440	19,362	0	86,802	0	86,802	-2,701	84,101
5. Heat and Other Utilities	0	0	202,774	202,774	0	202,774	3,911	206,685
6. Maintenance	67,078	0	97,820	164,898	0	164,898	2,488	167,386
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	684,600	317,678	318,529	1,320,807	0	1,320,807	-5,748	1,315,059
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	2,614,372	279,204	762,193	3,655,769	0	3,655,769	0	3,655,769
10a. Therapy	0	0	748,491	748,491	0	748,491	0	748,491
11. Activities	141,886	14,452	3,466	159,804	0	159,804	0	159,804
12. Social Services	76,922	0	2,671	79,593	0	79,593	0	79,593
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,833,180	293,656	1,540,821	4,667,657	0	4,667,657	0	4,667,657
17. Administrative	152,878	0	376,987	529,865	0	529,865	-376,987	152,878
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	60,309	60,309	0	60,309	11,717	72,026
20. Fees, Subscriptions & Promotion	0	0	41,128	41,128	0	41,128	856	41,984
21. Clerical & General Office	571,319	34,428	27,701	633,448	0	633,448	24,172	657,620
22. Employee Benefits & Payroll	0	0	544,692	544,692	0	544,692	78,277	622,969
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	1,943	1,943	0	1,943	2,968	4,911
25. Other Admin. Staff Trans	0	0	0	0	0	0	9,803	9,803
26. Insurance-Prop.Liab.Malpractice	0	0	191,923	191,923	0	191,923	3,839	195,762
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	724,197	34,428	1,244,683	2,003,308	0	2,003,308	-245,355	1,757,953
29. Total General Administrative	4,241,977	645,762	3,104,033	7,991,772	0	7,991,772	-251,103	7,740,669
30. Depreciation	0	0	56,985	56,985	0	56,985	186,050	243,035
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	20,491	20,491	0	20,491	314,202	334,693
33. Real Estate	0	0	0	0	0	0	416,864	416,864
34. Rent - Facility & Grounds	0	0	1,605,810	1,605,810	0	1,605,810	-1,605,810	0
35. Rent - Equipment & Vehicles	0	0	8,332	8,332	0	8,332	4,256	12,588
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,691,618	1,691,618	0	1,691,618	-684,438	1,007,180
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	215,547	0	215,547	0	215,547	0	215,547
40. Barber and Beauty Shop	0	0	15,086	15,086	0	15,086	0	15,086
41. Coffee and Gift Shops	0	0	4,714	4,714	0	4,714	0	4,714
42. Provider Participation	0	0	122,640	122,640	0	122,640	0	122,640
43. Other (specify):*	0	0	112,652	112,652	0	112,652	-112,652	0
44. Total Special Cost Ce	0	215,547	255,092	470,639	0	470,639	-112,652	357,987
45. Grand Total	4,241,977	861,309	5,050,743	10,154,029	0	10,154,029	-1,048,193	9,105,836

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	62,177	125,821
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,617,495	1,617,495
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	4,038	4,038
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	91,998	90,738
9. Other (specify):	0	0
10. Total current assets	1,775,708	1,838,092
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	57,196	57,196
13. Land	0	229,083
14. Buildings, at Historical Cost	0	5,353,558
15. Leasehold Improvements, Historical Cost	592,294	867,952
16. Equipment, at Historical Cost	222,267	842,673
17. Accumulated Depreciation (book methods)	-271,569	-2,679,694
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	87,999
24. Total Long-Term Assets	600,188	4,758,767
25. Total Assets	2,375,896	6,596,859
CURRENT LIABILITIES		
26. Accounts Payable	581,453	581,453
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	834,505	834,505
30. Accrued Salaries Payable	260,779	260,779
31. Accrued Taxes Payable	3,246	3,246
32. Accrued Real Estate Taxes	0	424,200
33. Accrued Interest Payable	0	40,135
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,377,067	121,881
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,057,050	2,266,199
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,859,166
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	402,063
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,261,229
46.Total Liabilities	3,057,050	7,527,428
47.Total Equity	-681,154	-930,569
48.Total Liabilities and Equity	2,375,896	6,596,859

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,158,234
2. Discounts and Allowances for all Levels	-958,818
Subtotal - Inpatient Care	7,199,416
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,304,992
7. Oxygen	2,051
Subtotal - Anciliary Revenue	1,307,043
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	6,355
13. Barber and Beauty Care	18,644
14. Non-Patient Meals	171
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	383,418
18. Sale of Supplies to Non-Patients	0
19. Laboratory	43,893
20. Radiologyand X-Ray	11,868
21. Other Medical Services	142,306
22. Laundry	2,701
Subtotal - Other Operating Revenue	609,356
24. Contributions	0
25. Interest and Other Investments Income	209
Subtotal - Non-Operating Revenue	209
27. Other Revenue (specify):	647
28. Other Revenue (specify):	0
Subtotal - Other Revenue	647
30. Total Revenue	9,116,671
31. General Services	1,320,807
32. Health Care	4,667,657
33. General Administration	2,003,308
34. Ownership	1,691,618
35. Special Cost Centers	347,999
35. Provider Participation Fee	122,640
37. Other	0
40. Total Expenses	10,154,029
41. Income Before Income Taxes	-1,037,358
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,037,358

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23	Provider Participation fee is linked from page 4